

**SHELBY COUNTY BOARD OF COMMISSIONERS
AGENDA ROUTE SHEET**

Referred to Commission Committee (name) _____

For Commission Action on (date) _____

DESCRIPTION OF ITEM: RESOLUTION APPROVING CIGNA INSURANCE COMPANY AS VENDOR FOR ALL SHELBY COUNTY GOVERNMENT EMPLOYEE LIFE AND DISABILITY INSURANCE COVERAGES. RESOLUTION SPONSORED BY COMMISSIONER GEORGE FLINN.

CHECK ALL THAT APPLY BELOW:

_____ This Action does NOT require expenditure of funds.

_____ This Item requires/approves expenditure of funds as follows (complete all that apply):

County General Funds: \$ _____ : County CIP Funds: \$ _____

State Grant Funds: \$ _____ : State Gas Tax Funds: \$ _____

Federal Grant Funds: \$ _____

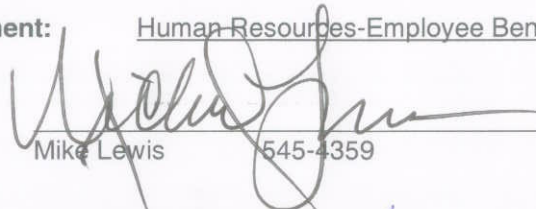
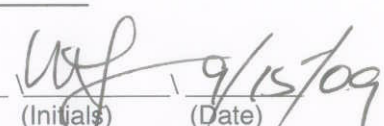
Other funds (Specify source and amount): Long Term Disability – 011-000000-2233- \$ 2,300,000.00
Life Insurance – 011-000000-2246- \$ 1,900,000.00

Other pass-thru funds (Specify source and amount): \$ _____

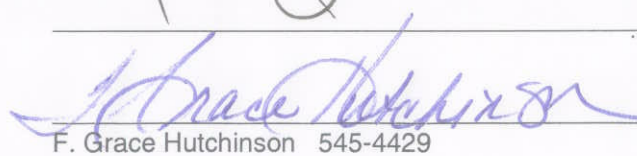
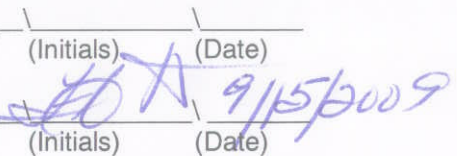
Originating Department: Human Resources-Employee Benefits

APPROVAL:

Dept. Head:

 
Mike Lewis 545-4359 (Initials) (Date) 9/15/09

Elected Official:

 
F. Grace Hutchinson 545-4429 (Initials) (Date) 9/15/2009


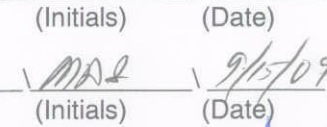
Division Director:

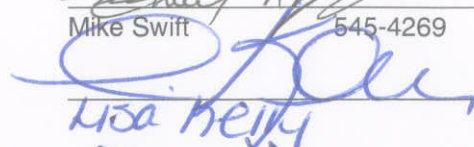
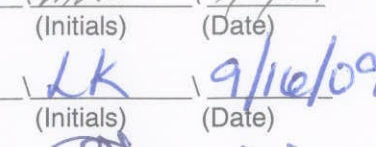
CIP – A&F Director:

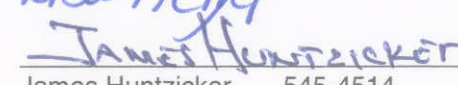
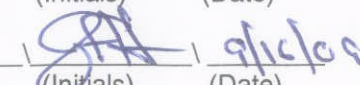
Finance Dept.:

County Attorney:

CAO/Mayor:

 
Mike Swift 545-4269 (Initials) (Date) 9/15/09

 
Lisa Henry (Initials) (Date) 9/16/09

 
James Huntzicker 545-4514 (Initials) (Date) 9/16/09

SUMMARY SHEET

I. Description of Items

RESOLUTION APPROVING CIGNA GROUP INSURANCE AS VENDOR FOR ALL SHELBY COUNTY GOVERNMENT EMPLOYEE LIFE AND DISABILITY INSURANCE COVERAGES. RESOLUTION SPONSORED BY COMMISSIONER GEORGE FLINN.

II. Source and Funding

Source - 011-000000-2233 Long Term Disability- \$ 2,300,000.00

Source - 011-000000-2246 Life Insurance - \$ 1,900,000.00

III. Contract Items

A. Type of Contract – Employee Life/Disability Insurance

B. Terms – 3 year contract commencing January 1, 2010

IV. Additional Information Relevant to Approval of this Item

The Administration Recommends Approval Of This Resolution.

Item # _____

PREPARED BY BRENDA GREENE

COMMISSIONER _____

APPROVED BY _____

RESOLUTION APPROVING CIGNA GROUP INSURANCE AS VENDOR FOR ALL SHELBY COUNTY GOVERNMENT EMPLOYEE LIFE AND DISABILITY INSURANCE COVERAGES. RESOLUTION SPONSORED BY COMMISSIONER

WHEREAS, The County offers a variety of life and disability coverages for employees and issued a Request for Proposals ("RFP") No. 09-006-94, Government Life and Disability Insurance June 25, 2009 and;

WHEREAS, The coverage includes Basic Life (30% paid by employee, 70% paid by Shelby County), Dependent Life (fully paid by employee), Supplemental Life (fully paid by employee), Accidental Death and Dismemberment (fully paid by employee), Short Term Disability (fully paid by employee) and Long Term Disability (fully paid by County) and;

WHEREAS, The County, in conjunction with its Consultant, The Segal Company, received proposals from seven (7) bidders on July 17, 2009 and CIGNA Group Insurance gave the best financially competitive bid response, and a three (3) year rate guarantee for all lines of coverage as shown in the attachment (Exhibit I), and;

WHEREAS, Some rates have been reduced from the current premium amount or remain the same. Employees will also be given the option to purchase an additional level of dependent life insurance of twenty five thousand dollars (\$25,000.00), and;

WHEREAS, The Administration recommends approving the application of CIGNA Group Insurance as the County's life and disability insurance carrier (Exhibit II).

NOW THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF SHELBY COUNTY, TENNESSEE, That CIGNA Group Insurance is awarded all employee life and disability coverages for a three (3) year period commencing January 1, 2010, subject to budget availability which includes Basic Life, Dependent Life, Supplemental Life, Accidental Death and Dismemberment, Short and Long Term Disability.

BE IT FURTHER RESOLVED, That the Mayor is hereby authorized to execute all necessary applications on behalf of Shelby County Government, copies of which are on file in the Contract Administration Department.

BE IT FURTHER RESOLVED, That the Mayor and the Director of the Division of Administration and Finance be and are hereby authorized to issue their warrants to CIGNA Group Insurance, according to the attached rates (Exhibit 1) and to take proper credit in their account therefor.

BE IT FURTHER RESOLVED, That this Resolution shall take effect from and after the date it shall have been enacted according to due process of law, the public welfare requiring it.

A C Wharton, Jr.
Shelby County Mayor

DATE _____

ATTEST:

Clerk of County Commission

ADOPTED _____

EXHIBIT 1

Financials – Summary by Product – Best and Final

	Current	Proposed					
		CIGNA		Hartford Life		MetLife	
		Initial	B&F	Initial	B&F	Initial	B&F
Employer Paid Annual Premium							
Basic Life	\$2,831,616	\$2,671,608	\$2,622,900	\$3,130,788	\$3,061,212	\$2,734,224	\$2,831,616
LTD	\$3,955,548	\$2,281,860	\$2,281,860	\$3,164,448	\$2,793,612	\$3,263,328	\$3,658,884
Total	\$6,787,164	\$4,953,468	\$4,904,760	\$6,295,236	\$5,854,824	\$5,997,552	\$6,490,500
Difference from Current (%)							
Basic Life		-6%	-7%	11%	8%	-3%	0%
LTD		-42%	-42%	-20%	-29%	-17%	-7%
Total		-27%	-28%	-7%	-14%	-18%	-4%
Difference from Current (\$)							
Basic Life		(\$160,008)	(\$208,716)	\$299,172	\$229,596	(\$97,392)	\$0
LTD		(\$1,673,688)	(\$1,673,688)	(\$791,100)	(\$1,161,936)	(\$692,220)	(\$296,664)
Total		(\$1,833,696)	(\$1,882,404)	(\$491,928)	(\$932,340)	(\$789,612)	(\$296,664)
Employee Paid Annual Premium							
STD	\$781,044	\$781,044	\$781,044	\$747,084	\$624,828	\$532,008	\$781,044
AD&D	\$26,969	\$26,969	\$24,272	\$33,334	\$21,818	\$25,269	\$26,969
Voluntary Life - EE	\$755,385	\$830,004	\$748,374	\$906,853	\$906,853	\$1,555,015	\$755,521
Voluntary Life - Spouse and Dependent	\$375,720	\$375,720	\$338,148	\$198,900	\$198,900	\$125,472	\$375,720
Total	\$1,939,117	\$2,013,737	\$1,891,838	\$1,886,170	\$1,752,399	\$2,237,764	\$1,939,253
Difference from Current (%)							
STD		0%	0%	-4%	-20%	-32%	0%
AD&D		0%	-10%	24%	-19%	-6%	0%
Voluntary Life - EE		10%	-1%	20%	20%	106%	0%
Voluntary Life - Spouse and Dependent		0%	-10%	-47%	-47%	-67%	0%
Total		4%	-2%	-3%	-10%	15%	0%
Difference from Current (\$)							
STD		\$0	\$0	(\$33,960)	(\$156,216)	(\$249,036)	\$0
AD&D		\$0	(\$2,697)	\$6,365	(\$5,151)	(\$1,699)	\$0
Voluntary Life - EE		\$74,619	(\$7,011)	\$151,468	\$151,468	\$799,630	\$136
Voluntary Life - Spouse and Dependent		\$0	(\$37,572)	(\$176,820)	(\$176,820)	(\$250,248)	\$0
Total		\$74,619	(\$47,280)	(\$52,947)	(\$186,719)	\$298,647	\$136
Grand Total	\$8,726,281	\$6,967,205	\$6,796,598	\$8,181,406	\$7,607,223	\$8,235,316	\$8,429,753
Difference from Current (%)		-20%	-22%	-6%	-13%	-10%	-3%
Difference from Current (\$)		(\$1,759,077)	(\$1,929,684)	(\$544,875)	(\$1,119,059)	(\$911,241)	(\$296,528)

Best and Final Notes:

1. CIGNA's voluntary life coverages are packaged with disability.
2. CIGNA's disability coverage is offered on a stand alone basis.
3. Standard proposes a 3 year rate guarantee on LTD with a contingent 4th or 5th year guarantee if the loss ratio on Life is .90 or better and the loss ratio on LTD is .80 or better.
4. MetLife's proposal is offered on a stand alone basis for life and disability.
5. Hartford's disability coverage is offered on a stand alone basis, however, life coverage is packaged with disability.

EXHIBIT 2

APPLICATION FOR GROUP INSURANCE

Applicant (Full Legal Name): State of Tennessee, County of Shelby, Shelby County Government

Address: 160 N. Main Street Suite 949

City: Memphis **State:** TN **Zip Code:** 38103

Taxpayer ID No.: 62-600841

Phone Number: 901.545.4939 **FAX Number:** 901.545.4942

The Applicant confirms receipt of a proposal from the Underwriting Company(ies) shown below and accepts the terms and conditions of the proposal and any attachments or modifications made to the proposal. The terms and conditions of the requested plan of insurance may vary in certain states as required by the laws of those states. Further, it is agreed the insurance applied for will not become effective unless this application is received and approved by the Underwriting Company(ies). Acceptability of the application is determined by the Underwriting Company(ies) and is based on current underwriting rules and requirements. If conflict exists between the proposal and the policy(ies), when issued, the terms of the policy(ies) will govern.

REQUESTED INSURANCE	REQUESTED EFFECTIVE DATE
COVERAGE: Group Basic & Voluntary Term Life	1/1/2010
UNDERWRITING COMPANY: Life Insurance Company of North America	
COVERAGE: Group Voluntary Accident	1/1/2010
UNDERWRITING COMPANY: Life Insurance Company of North America	
COVERAGE: Group Short-Term Disability	1/1/2010
UNDERWRITING COMPANY: Life Insurance Company of North America	
COVERAGE: Group Long Term Disability	1/1/2010
UNDERWRITING COMPANY: Life Insurance Company of North America	

If the number of eligible persons who enroll in the proposed insurance plan does not satisfy the participation requirements stated in the proposal, the Underwriting Company(ies) may, at its discretion, cancel the plan of insurance or adjust the rates or plan limits to reflect this difference. Premiums are payable as set forth in the policy(ies). If the Applicant collects premium from Insureds, Applicant will remit premium to the Underwriting Company(ies), or its Administrator, within 30 days. If premiums are not paid by the end of the Policy Grace Period coverage will end. Premiums are subject to change according to the terms and conditions set forth in the policy(ies).

The Applicant agrees to the following additional terms.

1. For any insurance paid for in part, or wholly, by plan participants, the Applicant will support enrollment activities and allow all eligible persons an opportunity to enroll.
2. No brochures or material referencing the requested insurance will be published without the prior review and written approval of the Underwriting Company(ies). The Applicant assumes full responsibility for any liability resulting from the use of written materials not prepared or approved by the Underwriting Company(ies).
3. The Applicant is the agent of its eligible persons for transactions relating to the requested insurance and will assume full responsibility for and not hold the Underwriting Company(ies) liable for any of the Applicant's wrongful acts or omissions.

4. The Applicant will promptly furnish any records or other information necessary to insure the proper administration of the insurance plans to the Underwriting Company(ies). The Applicant further agrees to allow the Underwriting Company(ies) or its Administrator to examine all records that pertain to the insurance plans. Any information furnished or obtained in connection with the administration of the insurance plan is confidential information. It shall not be released to any third party except as permitted by law and authorized by the party to which the information relates. That party will not use this information except in connection with the administration of the insurance plan.
5. If the Employee Retirement Income Security Act of 1974 (ERISA) applies, the Applicant is the Plan Administrator and Named Fiduciary of the employees' welfare benefit plan(s). Except as provided above or by ERISA and regulations thereunder, the Underwriting Company(ies) will provide no services in connection with ERISA compliance.
6. The consideration for the requested insurance is the Underwriting Company(ies)'s acceptance of this application and the Applicant's payment of the required premium when due. Payment of the required premium after delivery of the policy(ies) acts as acceptance of the terms and conditions of the policy(ies).

The Applicant represents that the information provided to the Underwriting Company(ies) to determine the terms of the insurance applied for is true and correct and forms the basis of the requested insurance.

IMPORTANT NOTE: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

ACCEPTANCE:

(Signature and Title of Applicant's Authorized Representative) Date: _____

Memphis, TN
(City and State)



CIGNA Group Insurance
Life · Accident · Disability

ERISA COVERAGE WORKSHEET

Use this worksheet to determine whether a policy is issued in conjunction with ERISA. Where a policy is issued in conjunction with ERISA, the following will apply:

1. The insurance company will serve as the employer's named fiduciary for handling claims in accordance with ERISA regulations. The "Appointment of Claim Fiduciary" is required.
2. Certificates of insurance will be prepared with ERISA Summary Plan Description wording included.
3. Information will be provided for the ERISA Annual Report, Form 5500, Schedule A.
4. Claim-related correspondence will comply with ERISA requirements, including notification of rights granted by ERISA regulations.

Name of Policyholder: State of Tennessee, County of Shelby, Shelby County Government Effective Date:

Life Policy No(s):	FLX980183	1/1/2010
Accident Policy No(s):	OK980209	1/1/2010
Disability Policy No(s):	LK980136, VDT980032	1/1/2010

In general, any group insurance policy issued to an employer to insure employees, or to a labor union to insure union members, is subject to ERISA. **All policies will be considered to be subject to ERISA unless one of the following exemptions applies.**

- ☐ The policy is not issued to insure employees of an employer, or members of a labor union.
- ☐ The policy is a statutory disability policy (e.g. Hawaii, New Jersey, New York).
- ☒ The policyholder is a government employer (e.g. state, county, city, special services district, public school district, public hospital, state college or university).
- ☐ The policyholder is a church group (religious organization, or hospital, school, or college operated by a religious organization) which has not made an election under IRC Section 410(d) to be subject to ERISA.
- ☐ The plan is a short-term, uninsured salary continuance plan funded with general assets of the employer.
- ☐ The plan is voluntary, funded entirely with employee contributions, and is not enrolled or endorsed by the employer; employer participation is limited to permitting the insurance company to conduct enrollments, and handling payroll deductions.
- ☐ None of the above exemptions apply. The policy is issued as part of an ERISA-covered employee benefit plan. **If this is the case, then the Policyholder should sign the next page, "Appointment of Claim Fiduciary," instead of this page.**

Implementation Coordinator

Policyholder Representative



CIGNA Group Insurance
Life • Accident • Disability

LIMITED AGENCY AGREEMENT

(Includes Employer FICA Services)

IMPORTANT: This is a Limited Agency Agreement which, under Internal Revenue Service regulations, permits an insurance company or other payor of taxable sick pay to make deposits of the employer portion of FICA taxes using the payor's employer identification number (EIN). In accordance with IRS regulations, the insurance company cannot make payments of employer taxes unless and until the Limited Agency Agreement is in effect. The insurance company cannot begin to make deposits of employment taxes on behalf of the employer until this agreement is signed and returned. Until the agreement is in place, the employer is solely responsible for timely filing all employment taxes.

**LIMITED AGENCY AGREEMENT
(Includes Employer FICA Services)**

Among: **LINA Benefit Payments, Inc. ("Payment Agent");**

And: Life Insurance Company of North America
 CIGNA Life Insurance Company of New York (collectively, "Company")

And: State of Tennessee, County of Shelby, Shelby County Government
 ("Employer")

Policies: LK980136

Effective Date: 1/1/2010

WHEREAS, Employer and Company have entered into one or more group disability insurance policies ("Policies") or Administrative Services Agreements ("ASO Agreements") under which Company, as Employer's agent, makes payments of taxable Sick Pay ("Sick Pay") to certain disabled employees of Employer; and

WHEREAS, such Sick Pay payments are or may be subject to the provisions of various regulations adopted by the U.S. Internal Revenue Service, relating to the withholding and payment of employment taxes, collection of income tax at the source, and reporting of payments and withheld taxes; and

WHEREAS, such regulations permit Employer and Payment Agent to enter into a Limited Agency Agreement under which Payment Agent will perform, as Employer's agent, certain specified services relating to the withholding and payment of employment taxes, collection of income tax at the source, and reporting of payments and withheld taxes; and

WHEREAS, Payment Agent is agreeable to performance of certain of such functions under this Agreement,

NOW, THEREFORE, in consideration of the mutual promises contained herein and in consideration of the issuance and continuance of the Policies and/or ASO Agreements, Payment Agent and Employer agree as follows, with respect to the Policies and/or ASO Agreements identified above:

I. TERM OF AGREEMENT; TERMINATION

- 1.) This Agreement shall be effective as of the later of the Effective Date shown above, and the date of approval granted by the Internal Revenue Code with respect to a properly completed Form 2678 relating to the services to be performed herein. This Agreement shall commence with respect to calendar years beginning on or after such effective date. This Agreement may be terminated at any time by either party, upon 30 days' written notice to the other. Payment Agent may immediately terminate this Agreement on written notice to Employer, if Employer fails to make any payment required hereunder. Payment Agent shall continue to be responsible for the preparation of Forms W-2 for calendar years ending while this Agreement is in force, but not thereafter.

II. DUTIES OF PAYMENT AGENT

- 1.) Payment Agent agrees to act as agent for the Employer, as well as any employers whose employees have coverage under the Plan, for the following purposes:

Preparation and filing of Form W-2, covering only Sick Pay paid by Company to payees under the Plan.

Withholding of federal income taxes, at the rate applicable to payments of supplemental wages, with respect to the taxable portion of Sick Pay.

Withholding of the employee portion of FICA taxes, with respect to the taxable portion of Sick Pay.

Payment of the Employer's portion of FICA taxes, with respect to the taxable portion of Sick Pay.

The Employer, or employers covered by the Plan, shall retain the sole and exclusive responsibility for all other duties required by any federal, state or local laws.

- 2.) Payment Agent shall:

- a. Deposit all withheld taxes with the appropriate federal depository on the due date thereof in accordance with the procedures under Section 6302 of the Code and the regulations thereunder, as now in effect or hereafter amended.
- b. Include such amounts so deposited in its Employer's Quarterly Federal Tax Return, Form 941.
- c. Prepare and file the annual Wage and Tax Statement, Form W-2 (and submit on magnetic tape), and mail each Employee with a copy of Form W-2 on or before January 31 of the year following the year in which the Sick Pay was paid.
- d. Prepare the required Federal Electronic filing and all appropriate state units of government or revenue authorities, and prepare and transmit any other forms or documents customarily prepared and transmitted in conjunction with such filing.

- 3.) Payment Agent shall use its own Employer Identification Number when making payments or filing reports or returns hereunder.
- 4.) Payment Agent agrees to make suitable arrangements for resolution of any questions raised by payees who receive Forms W 2 prepared by Payment Agent and, where appropriate, to issue revised Forms W-2.
- 5.) Payment Agent assumes no responsibility for the accuracy or inaccuracy of the information furnished to it by the Employer or any information which Payment Agent may include in any reports or filings which it prepares for Employer in reliance on such information. To the extent permitted by applicable law, Employer shall indemnify and hold harmless Payment Agent from any and all liabilities imposed upon Payment Agent in the event such information furnished by the Employer proves to be incorrect.
- 6.) Payment Agent assumes no responsibility for any other duties, actions or requirements imposed upon the Employer or upon any employers whose employees have coverage under the Plan, under any other provision of local, state or federal tax law.

III. DUTIES OF EMPLOYER

- 1.) Employer represents that the information contained in Schedule I hereof is true and correct.
- 2.) Employer shall notify Payment Agent of the portion of the disability payments made by Company which are excludable from gross income of payees at least sixty days before the beginning of the calendar year for which such portion is effective. Changes in such portion cannot be made at any other time.
- 3.) Employer agrees to provide Payment Agent on a timely basis with such information and documents as Payment Agent may reasonably need to discharge any functions which it assumes under this Agreement.
- 4.) With respect to any payments of Sick Pay made pursuant to ASO Agreements, Payment Agent shall withhold income taxes at the rate applicable to supplemental wages. Notwithstanding the foregoing, Employer may elect to determine the dollar amount of any income taxes to be withheld by Payment Agent and advising Payment Agent of such amounts. Where Employer elects to do so, Employer represents and warrants that it will correctly calculate the amount to be withheld, based on applicable federal withholding regulations, and based on net benefit amounts determined by Company to be payable.
- 5.) Unless the terms of the Policies provide that the Company waives its right to transfer liability with respect to the employer taxes imposed by IRS Regulation 32.1(e)(1), Employer shall provide Payment Agent with sufficient funds for the payment of Employer's portion of FICA taxes. Payment Agent may require a deposit of up to three months of estimated Employer FICA taxes and may create one or more bank accounts in which such funds shall be held. Payment Agent may draw upon such funds to reimburse itself for any Employer FICA taxes paid on Employer's behalf. Payment Agent shall not be required to pay Employer FICA taxes except from funds provided by Employer for this purpose.
- 6.) Payment Agent reserves the right to impose a charge for its services hereunder. Such charge may be set by Payment Agent with at least 30 days' written notice thereof prior to the start of any calendar year while this Agreement is in force, and shall, unless subsequently changed, be applicable to all calendar years thereafter.

IV. MISCELLANEOUS

Nothing contained herein shall be construed as creating any employment relationship between Payment Agent and any payee.

Any notices required or permitted to be given under the provisions of this Agreement shall be effective only if in writing and delivered either in person to the Employer's authorized agent or by First Class or U.S. Mail to the addresses set forth below, or to such other person or address as either party may designate in writing and deliver as herein provided:

Employer: Shelby County Finance and Administration
160 North Main
Memphis, Tennessee 38103
Attn.: James Martin

With a copy to: Shelby County Government
Contract Administration
160 N. Main St., Suite 550
Memphis, Tennessee 38103

Payment:

CIGNA Group Insurance
Tax Compliance Unit, LLTCU
900 Cottage Grove Road
Hartford, CT 06152

In the event either party is served with notice of any legal action in relation to this Agreement or the services provided hereunder, the party served with notice agrees to provide notice of same to the other party within ten (10) calendar days of receipt of notice. Failure to provide notice under this provision is waiver of any indemnity provision under this or any related contract.

This Agreement will be interpreted in accordance with the laws of the State of Tennessee. The parties agree that all actions, whether sounding in contract or in tort, relating to the validity, construction, interpretation and enforcement of this Agreement will be instituted and litigated in the federal or state courts within the State of Tennessee, having jurisdiction in Shelby County, Tennessee, and in no other.

IN WITNESS WHEREOF, and intending to be legally bound, the parties have signed this Agreement.

LINA Benefit Payments, Inc. ("Payment Agent")

Date: September 01, 2009

By: John A. Scanlon
Title: Assistant Secretary

("Employer")

Date: _____

By: _____
Title: _____

SCHEDULE I - EMPLOYER TAX INFORMATION

I. Exemption from Social Security/Medicare Taxes

Select appropriate reason if your disability plan is exempt from Social Security and Medicare taxes:

☐ Religious Institution ☐ Charitable Institution ☐ Other (Specify): _____

Indicate if Plan is issued to a union, a creditor, or an association which is exempt from Social Security taxation if the employer is neither a party to the contract or a contributor to plan costs:

☐ Union ☐ Creditor ☐ Professional Association

II. Employee Contribution Percentages

Short Term Disability:

- ☒ All employees contribute **100%** of disability policy premium on a post-tax basis.
☐ Employees contribute on a pre-tax basis (considered 100% employer contributions).
☐ Employer contributes 100% of cost.
☐ Contribution percentage varies by benefit, plan or division (attach detail).

Long Term Disability:

- ☐ All employees contribute _____% of disability policy premium on a post-tax basis.
☐ Employees contribute on a pre-tax basis (considered 100% employer contributions).
☒ Employer contributes 100% of cost.
☐ Contribution percentage varies by benefit, plan or division (attach detail).

III. Tax Reporting of Self-Insured Benefits (Does not apply to "advice to pay")

- ☐ Benefits are paid from a trust (e.g. 501(c)(9) trust) which bears an insurance risk.

Indicate the address where the ASO tax reimbursement check should be sent:

Attention: _____

Mailing Address: _____

IV. Address to which tax reports should be sent

- ☒ All reports should be sent to the following address:

Attention: Jim Martin

Mailing Address: 160 N. Main Street, Suite 949

Memphis, TN 38103

- ☐ Reporting should be to multiple addresses. Attach information on a separate page. Include suffix/division code, coverage code, employee post-tax contribution percentage, federal EIN and employer address.

BENEFIT DEDUCTION SERVICES AGREEMENT

Company: ☒ **Life Insurance Company of North America**
☐ **CIGNA Life Insurance Company of New York**

Employer State of Tennessee, County of Shelby, Shelby County
Government

Policy No. VDT980032, LK980136

Eff. Date STD/LTD 1/1/2010

WHEREAS, Employer sponsors various health and welfare benefits for its employees, and such benefits continue to be available to disabled employees ("Claimants") receiving disability benefits under the Policy; and

WHEREAS, Employees participating in such benefits have authorized Employer to deduct amounts payable therefore from benefits under the Policy; and

WHEREAS, Employer desires that Company make such deductions from benefit payments to such Claimants as have authorized such deductions, from benefits paid by Company under the Policy; and

WHEREAS, Company, in consideration of the insurance premiums, is willing to provide such services on the terms contained herein;

IN CONSIDERATION OF the mutual promises herein contained, and of Employer's timely payment of premiums under the Policy, Company and Employer agree as follows.

1. Company will deduct from benefit payments to Claimants under the Policy employee contributions for (1) health and welfare benefits provided to Claimants under a plan sponsored by Employer; (2) group life insurance benefits provided to Claimants under a plan sponsored by Employer; and (3) such other benefits as Company permits.
2. Employer shall, with its initial claim information, provide Company with information regarding the amount of deductions which each Claimant has authorized, and whether such deductions are taken on a pre-tax or post-tax basis. Employer shall provide Company with at least 31 days' prior notice if any deduction amount changes. Company shall not be required to take deductions unless it timely receives required information from the Employer. Company reserves the right to require evidence that any Claimant has authorized deduction from benefits under the Policy.
3. Company shall, on a monthly basis, provide Employer with a listing of amounts deducted, itemized by Claimant and type, and shall remit to Employer the aggregate amount deducted from benefits paid to Claimants.
4. Where Company prepares W-2 Wage and Tax Statements with respect to benefits, Company shall, where and in the manner required, report deductions taken from benefits during the calendar year.
5. Employer represents and warrants that all Claimants for whom it requests deductions from benefits have duly authorized such deductions to be made from benefits under the Plan, and that the amount to be deducted is accurate.

6. Employer agrees that all amounts deducted by Company from benefits paid to Claimants shall be timely applied for the purposes for which Claimants have authorized.
7. To the extent permitted by applicable law, Employer agrees to indemnify, defend and hold Company harmless against any claims, demands or lawsuits initiated by or on behalf of Claimants, related directly or indirectly to the actions taken by Company in performing its obligations under this Agreement.
8. Either party may terminate this Agreement at any time upon 31 days' written notice.
9. Any notices required or permitted to be given under the provisions of this Agreement shall be effective only if in writing and delivered either in person to the Employer's authorized agent or by First Class or U.S. Mail to the addresses set forth below, or to such other person or address as either party may designate in writing and deliver as herein provided:

Employer: Shelby County Finance and Administration
160 North Main
Memphis, Tennessee 38103
Attn.: James Martin

With a copy to: Shelby County Government
Contract Administration
160 N. Main St., Suite 550
Memphis, Tennessee 38103

Company: Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192
Attn.: Group Insurance Underwriting

10. In the event either party is served with notice of any legal action in relation to this Agreement or the services provided hereunder, the party served with notice agrees to provide notice of same to the other party within ten (10) calendar days of receipt of notice. Failure to provide notice under this provision is waiver of any indemnity provision under this or any related contract.
11. This Agreement will be interpreted in accordance with the laws of the State of Tennessee. The parties agree that all actions, whether sounding in contract or in tort, relating to the validity, construction, interpretation and enforcement of this Agreement will be instituted and litigated in the federal or state courts within the State of Tennessee, having jurisdiction in Shelby County, Tennessee, and in no other.

IN WITNESS WHEREOF, and intending to be legally bound, the parties have signed this Agreement.

**X LIFE INSURANCE COMPANY OF
NORTH AMERICA**

☐ **CIGNA LIFE INSURANCE COMPANY
OF NEW YORK**

Date: 09/01/2009

By: Matthew G. Monahan
Title: President

State of Tennessee, County of Shelby, Shelby County
Government
("Employer")

Date: _____

By: _____
Title: _____

Subscription and Joinder Agreement

TRUST: **The Group Insurance Trust for Employers in the
Public Administration Industry**

The Applicant adopts the above named Trust established for all employers in the same or related industry and subscribes to the Trust for the insurance requested in the attached Group Application. For the purposes of this agreement the Applicant will be known as the Subscriber.

SUBSCRIBER:

The Subscriber confirms the appointment of Wilmington Trust Company as Trustee and agrees to be bound by the terms of the Trust Agreement. By signing this agreement, the Subscriber joins as Co-Settlor of the Trust until its termination as a Subscriber and accepts the appointment of the Administrator.

The Subscriber agrees to the following terms.

1. The Subscriber agrees to promptly furnish the Trustee or its Administrator with records or other information required by them as needed to ensure proper administration of the insurance plans of the Trust. It further agrees to allow the Trustee or its Administrator to inspect all records that pertain to the insurance plans of the Trust.
2. The Subscriber appoints the Administrator to represent it in dealings with the Trustee which have to do with the insurance fund. In the event of its termination as a Subscriber, no further claim, except as may be provided under any extended benefits provision of the policy, will be made against any funds accruing to any portion of the insurance fund.
3. The Subscriber agrees to pay the Trustee or its Administrator all premiums which become due and payable, and understands that any payment more than 31 days in default may cause the termination of this Agreement and suspension of all benefits as of the due date.
4. Either the Subscriber or the Trustee may terminate this agreement upon 30 days written notice to the other.
5. Any notices required or permitted to be given to the Subscriber in connection with the Trust, or any policies issued to the Trustee for the benefit of Subscriber's employees, shall be effective only if in writing and delivered either in person to the Subscriber's authorized agent or by First Class or U.S. Mail to the addresses set forth below, or to such other person or address as either party may designate in writing and deliver as herein provided:

Subscriber: Shelby County Finance and Administration
 160 North Main
 Memphis, Tennessee 38103
 Attn.: James Martin

With a copy to: Shelby County Government
 Contract Administration
 160 N. Main St., Suite 550
 Memphis, Tennessee 38103

6. Except to the extent required by the terms of any policy issued to the Trustee, this Agreement will be interpreted in accordance with the laws of the State of Tennessee. The parties agree that all actions, whether sounding in contract or in tort, relating to the validity, construction, interpretation and enforcement of this Agreement will be instituted and litigated in the federal or state courts within the State of Tennessee, having jurisdiction in Shelby County, Tennessee, and in no other.
7. Shelby County Government is a governmental entity and, as such, is governed under the Governmental Tort Liability Act. As a governmental entity, Shelby County Government is unable to indemnify or otherwise insure any other entity or person and expressly disavows any provision herein which would require it to do so.

Subscriber (Employer Name): State of Tennessee, County of Shelby, Shelby County Government
OK980209, FLX980183

By: _____
Signature

Date

Name/Title

Date Accepted: 09/01/2009

Wilmington Trust Company (Trustee)

by Life Insurance Company of North America
(Administrator)

Matthew G. Manders

Matthew G. Manders, President



CIGNA Group Insurance
Life • Accident • Disability

Authorization of Payment of Commissions and Service Fees

We hereby appoint The Segal Company as our broker of record in connection with the policy, as of its effective date, and continuing unless and until we notify the insurance company in writing of revocation of this appointment. Any revocation of appointment, or designation of a new broker of record, will become effective on the date written notice is received by the insurance company, or such later date as we specify.

We authorize payment of commissions to the broker at the following rates:

Producer	Policy Numbers
Life	FLX980183
Accident	OK980209
STD	VDT980032
LTD	LK980136

Product	Premium	Percentage
Life – Basic & Voluntary Effective Date: 1/1/2010	Flat	1%
Accident – Voluntary Effective Date: 1/1/2010	Flat	1%
STD – Voluntary Effective Date: 1/1/2010	Flat	1%
LTD Effective Date: 1/1/2010	Flat	1%

We understand and acknowledge that CIGNA Group Insurance companies may have entered into, or may enter into, an agreement with the broker, under which the insurance company compensates the broker for providing marketplace intelligence and other services intended to enhance the effectiveness of the insurance company's business. This additional compensation is contingent on meeting new business and persistency goals.

The following describes the compensation available under the program under which your broker is eligible to participate. Terms of the program are subject to change.

- **New Business.** Payments made are a percentage of total commissions, based on number of new cases sold and annualized premium, and range from 0% to 55% of the amount of expected first year commissions (which is the maximum rate payable, if at least 50 lines of coverage, or at least \$1,250,000 in premium, is sold). Payments are a percentage of standard commission if no commissions are otherwise payable.
- **Persistency.** Persistency measures the number of policies (weighted by premium) which were in force at the beginning of the year which are still in force at the end of the year. Payments made are a percentage of total commissions, and range from 0% to 20% of commissions (which is the maximum rate payable, if persistency is 95% or greater). Brokers must have a book of business of at least \$250,000 at the start of the year, or write at least \$200,000 of new business premium or three new cases, to qualify. Payments are a percentage of standard commission if no commissions are otherwise payable.

This compensation is funded from the insurance company's overhead and is based on the broker's overall book of business with the insurance company. Any such payments are separate from commissions and, if applicable, will be included in ERISA Form 5500, Schedule A information provided by the insurance company.

We also understand that the insurance company may invite the broker to participate in events sponsored by the insurance company for the same purposes.

Authorized Signature
State of Tennessee, County of Shelby, Shelby County Government

Date



CIGNA

A Business of Caring.

Important Privacy Notice – Please Read

As a customer of a CIGNA company¹, we want to assure you that we recognize our obligation to keep our customers' protected information secure and confidential. This notice explains our privacy practices and it should answer questions about how we protect personal information. We will continue to safeguard the privacy of the information provided to us. Thank you for giving us the opportunity to serve you. (If you are an Employer or Group Sponsor, please make this information available for review by your employees or members as appropriate.)

This notice applies to insurance products underwritten, or administered by, the Life Insurance Company of North America and CIGNA Life Insurance Company of New York, Life and Disability products underwritten by Connecticut General Life Insurance Company, and insurance products underwritten by Insurance Company of North America administered by the CIGNA companies. Information is the key to our ability to provide you with best in class service. Regardless of whether you are a customer, applicant, insured, or former insured, we are committed to protecting and maintaining the privacy of any information in our possession.

COLLECTION AND USE OF INFORMATION

We may collect protected information about our customers for use in the processing and evaluation of applications or eligibility for insurance, investigating a claim for benefits, and in developing financial plans. This information will be used by authorized company personnel solely for these purposes, and it may be integrated into our databases for statistical and audit purposes. Protected information means any non-public, personally identifiable information including financial information, employment related information and medical information. Unless permitted by law, we will only collect information from sources other than our customers with authorization.

DISCLOSURE OF INFORMATION

We do not disclose any protected information about our customers or former customers to anyone except as permitted by law. We do not sell customer lists or other protected information. With some exceptions, we will not disclose protected information without written authorization. There are circumstances when we will disclose protected information related to medical underwriting or a claim investigation or other activities relating to your insurance plan without authorization to third parties or affiliates assisting us with these activities, as permitted by law. We will also disclose protected information to third parties without authorization as required by law, such as in the case of subpoenas and mandated governmental disclosures.

PROTECTING YOUR INFORMATION

We have internal policies to maintain the privacy of our customers' protected information. These include but are not limited to policies related to the transmission, storage and disposal of paper and electronic information; the prevention of unauthorized access and damage to systems, including damage due to environmental hazards; and assigning and terminating user IDs.

¹ "CIGNA" is a registered trademark licensed for the use of insurance company subsidiaries of CIGNA Corporation. All products and services are provided by insurance company subsidiaries and not the corporation itself. As used herein, "CIGNA" refers to these subsidiaries, which include the Life Insurance Company of North America, CIGNA Life Insurance Company of New York and Connecticut General Life Insurance Company.

Request for Taxpayer Identification Number and Certification

Give form to the
requester. Do not
send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return) Life Insurance Company of North America	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ <input type="checkbox"/> Exempt from backup withholding	
Address (number, street, and apt. or suite no.) 1601 Chestnut Street	Requester's name and address (optional)
City, state, and ZIP code Philadelphia, PA 19192	
List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number								
or								
Employer identification number								
2	3	1	5	0	3	7	4	9

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign
Here

Signature of
U.S. person ▶

Karen A. Khan

Date ▶

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

GRATUITY DISCLOSURE FORM**Shelby County Ethics Commission**

***INSTRUCTIONS:** This form is for all persons receiving any Shelby County Government contract, land use approval or financial grant money to report any gratuity that has been given, directly or indirectly, to any elected official, employee or appointee (including their spouses and immediate family members) who is involved in the decision regarding the contract, land use approval, or financial grant of money.*

1. NAME

Scott Carlisle, CIGNA

2. DATE OF GRATUITY

None

3. NATURE AND PURPOSE OF THE GRATUITY

NA

4. NAME OF THE OFFICIAL, EMPLOYEE, APPOINTEE, OR FAMILY MEMBER WHO RECEIVED THE GRATUITY

NA

5. NAME OF THE PERSON OR ENTITY THAT PROVIDED THE GRATUITY

NA

6. ADDRESS OF THE PERSON OR ENTITY THAT PROVIDED THE GRATUITY

NA

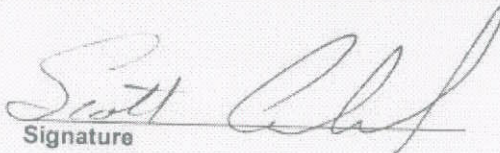
7. DESCRIPTION OF THE GRATUITY

NA

8. COST OF THE GRATUITY (If cost is unknown and not reasonably discernible by the person giving the gratuity, then the person giving the gratuity shall report a good faith estimate of the cost of the gratuity.)

NA

9. The information contained in this Gratuity Disclosure Form, and any supporting documentation or materials referenced herein or submitted herewith, is true and correct to the best of my knowledge, information and belief and affirm that I have not given, directly or indirectly, any gratuity to any elected official, employee or appointee (including spouse and immediate family members) that has not been disclosed and I affirm that I have not violated the provisions of the Shelby County Government Code of Ethics.


Signature

9/14/2009

Date

Scott Carlisle
Print Name

A copy of your completed form will be placed on the Shelby County Internet website.



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

02/20/2009

PRODUCER

MARSH USA Inc.
TWO LOGAN SQUARE
PHILADELPHIA, PA 19103
Attn: Healthcare.AccountsCSS@marsh.com/FAX: 212 948-1307

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

100607-CIGNA-CAS-08-09 EOI

INSURERS AFFORDING COVERAGE

NAIC

INSURED

CIGNA CORPORATION AND ITS SUBSIDIARIES
TWO LIBERTY PLACE, TL15B
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2438

INSURER A: ACE American Insurance Company

22667

INSURER B: N/A

N/A

INSURER C: N/A

N/A

INSURER D:

INSURER E:

COVERAGES

3

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADDL INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A		GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR GENERAL AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC	HDOG23740102	07/01/08	07/01/09	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES(Ea occurrence) \$ 1,000,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000
A		AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS	ISAHO7837173	07/01/08	07/01/09	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$ OTHER THAN EA ACC \$ AUTO ONLY: AGG \$
		EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE DEDUCTIBLE RETENTION \$				EACH OCCURRENCE \$ AGGREGATE \$ \$ \$ \$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				WC STATU- TORY LIMITS OTH- ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
		OTHER				

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS
EVIDENCE OF INSURANCE

CERTIFICATE HOLDER

CLE-002033997-01

CANCELLATION

CIGNA CORPORATION
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Mary Radaszewski

IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

The Certificate of Insurance on the reverse side of this form does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

ADDITIONAL INFORMATION

CLE-002033997-01

DATE (MM/DD/YY)
02/20/2009**PRODUCER**

MARSH USA Inc.
TWO LOGAN SQUARE
PHILADELPHIA, PA 19103
Attn: Healthcare.AccountsCSS@marsh.com/FAX: 212 948-1307

100607-CIGNA-CAS-08-09 EOI

INSURERS AFFORDING COVERAGE**NAIC #****INSURED**

CIGNA CORPORATION AND ITS SUBSIDIARIES
TWO LIBERTY PLACE, TL15B
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2438

INSURER F:

INSURER G:

INSURER H:

INSURER I:

TEXT

"IF EVIDENCE OF COVERAGE IS NO LONGER REQUIRED, KINDLY RETURN THE CERTIFICATE MARKED "NO LONGER REQUIRED", AND WE WILL ADJUST OUR FILES ACCORDINGLY."

CERTIFICATE HOLDER

CIGNA CORPORATION
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Mary Radaszewski

